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Making Space for Embedded Knowledge in Global Mental Health: A role for social work?

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The ‘Global Mental Health’ (GMH) movement, an influential driver of transnational knowledge transfer in the field of mental health, advocates evidence-based strategies to ‘scale up’ services in low- and middle-income countries. As with debates on global and local frameworks for social work, there are concerns about marginalisation of knowledge that does not neatly fit the GMH discourse. This article analyses the professional and disciplinary structures that shape knowledge transfer in GMH and the implications for social work’s engagement with the movement. Analysis of key documents and secondary literature identifies three key issues for GMH: its potentially negative impact on ‘local’ knowledge production; the challenges of accounting for culture and context; and the selective forms of evidence that are ‘allowed’ to contribute to GMH. Finding ways to encompass more ‘situated’ perspectives could reshape GMH in accord with its aspirations for participation by a wider range of stakeholders. Social work’s values-based commitment to rights and empowerment, emphasis on embedded knowledge emerging from close links with practice, and theoretical engagement with social, cultural and political context, enable the profession to contribute significantly to this task. Such engagement would bring improvements in care for those suffering from mental health disorders, their families and communities.

Keywords: global mental health; knowledge transfer; international social work; indigenisation; global social work

Introduction

International social work knowledge transfer both within and beyond the discipline has grown in importance. This ‘global turn’ (Harrison and Melville, 2010, p. 1) culminated in the Global Agenda for Social Work and Social Development (IFSW / IASSW / ICSW, 2010), which represented a significant push towards a more cohesive global consciousness within the profession. In this respect, social work is doing no more than keeping pace with the discourse, agendas and expertise of other professions, as increased international communications reshape flows of knowledge within and between disciplines and policy settings. This wider dynamic is visible in developments in a key area of concern to social work, mental health, where the dominance of some sources of knowledge and the peripherality of others are cast into sharp relief by the growth of ‘Global Mental Health’ (GMH). While GMH is a disparate field which encompasses varying perspectives, familiar tensions between the generalisable policy appeal of evidence-based medicine approaches and more meaning-focused, emergent knowledge that is ‘embedded’ in context (Gould, 2006), can be detected as its influence grows. This presents both challenges and opportunities for the profession of social work.

The relevance of social work’s more global outlook is contested. Critics have suggested that the notion of ‘global social work’ is a ‘vanity’ without practical impact, that it is more about enhancing the status of professional institutions than the good of wider society, or that it is an imperialist endeavour reinforcing the dominance of the ‘global North’ over the ‘global South’ (Gray and Webb, 2008; Webb, 2003). They question its relevance to social work practitioners, but also highlight the potential for internationally ‘homogeneous standards’ to overpower indigenous, ‘embedded’ or local knowledge, values and practices (Gray and Webb, 2008, p. 62). Against this argument, Jones and Truell (2012) advocate the general adoption of the Global Agenda’s basic ethical principles, while emphasising the importance

of ongoing discussion to accommodate the diversity of worldwide concerns. Perceptively, they also highlight the fact that this debate cannot treat social work in isolation, but must recognise that it exists alongside multiple other professions who are also fully engaged in global knowledge transfer (ibid, p. 464). Social work cannot help but be caught up in these developments.

Gray and Webb raise important concerns. However, as becomes clear when the sometimes abstract debates around the Global Agenda are re-contextualised with reference to specific processes such as the rise to policy influence of GMH, standing aside has its costs (often primarily to service users and carers), as other professions and institutions then define the terms of the debate. This article identifies three tendencies in aspects of GMH that give rise to concern and draws on selected case studies to suggest that it is precisely by championing embedded, local and/or participatory knowledge that social work can make its biggest contribution to the coalescing global forms of knowledge on mental health.¹ Seen in this light, neither refusal to engage in global knowledge exchange, nor uncritical embrace of it, are acceptable options. At the same time, exploration of this field raises the question of how far social work knowledge has the scope to travel beyond the profession – to what extent can we make our voices heard? Answering this question requires exploration of how the field of GMH is currently constituted.

¹ Of course, social work knowledge itself is contested, with a recent review identifying at least 10 different models of social work knowledge production (Gray and Schubert, 2013). Yet what all these models have in common is that they find themselves wrestling with how to reconcile different sources of knowledge, that range from disembodied RCTs and meta-analyses, to highly contextualised practitioner and service user experience. The persistence with which social work seeks to keep both sides of this equation in play is perhaps its real strength in contributing to debates over the use to which what we think we know should be put.

Global Mental Health

The term ‘Global Mental Health’ now refers to a collection of related initiatives that aim to move mental health problems up the policy agenda and thereby vastly extend the reach of mental health services within low and middle-income countries (LAMICs). Its origins lie in a series of reports from the World Health Organisation (WHO, 2001, 2004) that drew attention to the extent of the burden that poor mental health places on national economies and individual well-being. The data presented highlighted the extent of the ‘treatment gap’ in many parts of the world – in other words, the disparity between mental health needs and the resources available to meet them (WHO, 2008). The impetus for change that this provided has found a number of outlets, including the *Mental Health Atlas* (WHO, 2011), a regularly updated map of mental health resources around the world; the 2007 and 2011 *Lancet* series, surveys of the field that culminated in an impassioned call to action arguing for the ‘scaling up’ of mental health provision in LAMICs (Lancet Global Mental Health Group, 2007; Patel *et al.* 2011); and the Mental Health Gap Action Programme (WHO, 2008), a series of evidence reviews examining effective therapeutic approaches in LAMICs. The US-based National Institute for Mental Health (NIMH) and the Wellcome Trust are among funding bodies who have thrown their weight behind research efforts to meet the ‘Grand Challenges in Global Mental Health’ (Collins *et al.* 2011).

In symbiosis with the initiatives developed through such high-status international organisations, medical journals and research funders, a more participatory coalition has sprung into being to advance the aims of GMH. This is the Movement for Global Mental Health (MGMH), which has now developed into an influential campaign seeking to promote ‘scientific evidence and human rights’ in ‘services for people with mental disorders worldwide,’ though with a particular focus on LAMICs (MGMH, n.d. (a)). Through its

website and networking activities, the movement provides a forum for collaboration and knowledge transfer among participants, who include professionals and workers in mental health, activists, researchers, policy advocates, and individuals affected by mental disorders and their families. While the MGMH recognises that it largely originated with, and remains heavily influenced by, members based in high-income countries (HICs), there is a drive to expand participation from LAMICs and by service users (MGMH, n.d. (b)).

Given the lack of attention paid to mental health issues until recently, the achievements of GMH have been significant. Mental health has been brought into the development agenda (WHO, 2010); attention has been drawn to human rights violations in the care of those with mental disorder (WHO, 2012; Dudley *et al.*, 2012); and a comprehensive Global Mental Health Action Plan 2013-2020 (WHO, 2013) should give mental health a higher priority in national policies. NGOs, higher education courses and projects are emerging in the suddenly vital field of GMH. Although significant shortcomings remain and not all these developments have yet translated into meaningful impact on the frontline, the improvement of mental health services and strengthening of rights is to be applauded. Yet it is important not to lose sight of what forms of knowledge about mental health are being transmitted and the routes through which this occurs.

Although unified in its aims and core principles, GMH can be seen as a conjuncture of functions and elements held together as much by agreements of convenience as by any tightly-knit conformity. Achieving coherence requires articulation between different elements; for example, the programmatic GMH agenda set by flagship publications by the WHO, *Lancet* and *PLoS* cannot necessarily be immediately reconciled with the commitment to participatory, ‘bottom up’ approaches professed by many adherents of the MGMH. This

internal diversity allows GMH to take an assimilative approach to critique; while on the one hand it offers global solutions to mental health challenges, on the other it can emphasise local solutions grounded in social development (see Bemme and d'Souza, 2012), without falling into self-contradiction. However, it also requires that the twin guiding lights proclaimed by the MGMH – ‘scientific evidence’ and ‘human rights’ – not be defined too rigorously, for they are not nearly as uncomplicated as they appear. Although the movement occupies a common platform, the way GMH knowledge flows indicates certain tensions within it.

Global Mental Health, Scientific Evidence and Human Rights

The reference to ‘scientific evidence’ alludes to evidence-based policy and practice, which has become the dominant paradigm within medicine, and increasingly within social care also. Resources such as the *PLoS Med* collection of papers on ‘packages of care’ for mental, neurological and substance use disorders, which reviews best evidence for working with depression, epilepsy, schizophrenia, alcohol use disorders, dementia and attention-deficit hyperactivity disorder², serve as the basis of this approach. However, the tables presented, summarising the studies that support various treatment approaches, are in fact drawn predominantly from studies in HICs, with considerably less evidence available from LAMICs (even where included HICs studies have been limited to systematic reviews, meta-analyses and ‘key trials,’ while LAMICs studies have included RCTs and longitudinal studies, e.g., Patel et al., 2009; Mari et al., 2009). The authors lament the paucity of high-quality evidence from LAMICs and the consequent need to rely on studies from HICs, but – faced with the limited research in much of the world and resulting lack of data – see no alternative (Patel *et al.*, 2009, p. 1; Mari *et al.*, 2009, p. 1). They do not assume that findings will necessarily be transferable from HICs to LAMICs, but their methodology and the limits of the data lead

² See <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2747279>.

them to proceed as if they had. While it can certainly be argued that this is the most sensible way of proceeding under the circumstances, taking an approach to this kind of transnational knowledge transfer that treats it – even reluctantly – as uncomplicated raises a number of issues.³ Three of these seem particularly pertinent.

Who takes precedence in the production of knowledge? First, there is the question raised by Behague *et al.* (2009) in their discussion of evidence-based policy knowledge transfer to LAMICs in the field of maternal health: does it distort the framework within which local initiatives and alternative approaches to problem-solving could develop? Undertakings such as the ‘package of care’ collection aim to develop generalisable, replicable practice recommendations ‘that can be applied systematically and similarly in most countries’ (ibid, p. 1540); there is a risk that this may have a deadening effect on the potential diversity of therapies and research methodologies that might otherwise be tried and adapted to suit local contexts. It is interesting to note that this is potentially in very sharp counterpoint to such person-centred and flexible approaches as the recovery model, for example, which have become increasingly influential in HICs (Leamy *et al.*, 2012; Topor *et al.*, 2011). Moreover, it is an approach which currently sits somewhat uneasily with the aspirations of GMH to be a bottom-up movement that shifts power from ‘places like Montreal to places like Delhi’

³ Not least among these is the issue of whether, rather than LAMICs learning from HICs about mental health care, the reverse should be the case. Although we do not treat the debate in detail here, there is some evidence that schizophrenia outcomes may be better in LAMICs, despite the ‘treatment gap’ (Jääskeläinen *et al.*, 2013; Warner, 2009). The methodology and findings of these studies are disputed by the leaders of the MGMH and others (Cohen *et al.*, 2008; Burns, 2012). We suspect that sweeping generalisations about the ‘developed’ and ‘developing’ worlds are unhelpful and would call for more ‘embedded’ research that engages the specific characteristics of particular settings (Burns, 2012), but note that this does suggest that increased access to psychiatric care may not be the only way to improve mental health in poorly-resourced settings.

(Patel, cited in Bemme and D'Souza, 2012); while mental health workers in LAMICs may find their position and methods buttressed in some respects by the credibility conferred by international systematic reviews, they may also find national 'experiential knowledge and the credibility of locally-generated solutions [undermined]' (Behague *et al.*, 2009, p. 1543). Just as importantly, and a matter of primary concern for social work, what scope is there for solutions to be generated and recognised by communities and service users themselves (Petersen *et al.*, 2012)? The research resources and expertise valued by the international community are far from equitably distributed, and while innovative activities may be underway in different localities, without external support it is often difficult in low-income settings to employ the approaches to evaluation that would qualify them for inclusion in reviews of this kind (Hickling, cited in Bemme and D'Souza, 2012). Our intention here is not to deny the value of such evidence-based reviews in establishing treatment efficacy; rather it is to highlight the potentially skewed inputs that lead to their conclusions, and query what the implications are for the forms of knowledge that GMH produces. If used with discernment to inform rather than dictate practice, this work will be highly beneficial, but Behague *et al.* (2009) describe how transnational evidence-based policy making all too often stifles national and local initiatives, as policy makers and funders insist on particular forms of practice corresponding to international best evidence. Social workers in many countries are only too familiar with the difficulties of achieving recognition of indigenous knowledge production (Gray *et al.*, 2008; Kreitzer *et al.*, 2009). The profession's experience of wrestling with such issues should inform GMH's engagement with the same questions.

How do global forms of knowledge address specificity, social context and culture? The cultural appropriateness of GMH has been the subject of vexed criticism (Mills, 2014). While the 'strong' form of cultural relativism, according to which understandings developed in one

‘culture’ can have no relevance in another, is increasingly untenable in an era of globalisation and interaction, concerns for how best to tailor GMH approaches to local historical, cultural and socioeconomic realities remain valid, as GMH advocates themselves recognise (Chowdhary *et al.*, forthcoming). Cultural considerations have led to the development of alternative approaches to therapy in Europe, through work such as Tobie Nathan’s *ethnopsychiatrie* model in France (wa Tshiekedi, 2009) or de Martino’s use of ‘critical ethnocentrism’ in mental health work in Italy (Stanghellini and Ciglia, 2013), and, in North America, through such techniques as the cultural formulation (Aggarwal *et al.*, 2013). There has been less recognised and systematic work on cultural adaptation in most LAMICs, despite the extent of cultural diversity, disparities of wealth and cultural capital, and conceptualisations of mental illness within many countries. Aisenberg (2008) and Kirmayer (2012) have pointed out the tensions between evidence-based practice’s need for generalisability and the attention to diversity that characterises such alternative orientations as ‘cultural competence’ or ‘cultural humility,’ or attempts at indigenisation of practice. On looking at the ‘package of care’ evidence cited from LAMICs, the problems of generalisability are stark: the efficacy of many psychosocial therapies is evaluated on the basis of studies in a single country (e.g., Mari *et al.*, 2009; Patel *et al.*, 2009). This is not to criticise the authors of these reviews, who must grapple with the lack of widespread evaluations in drawing up their recommendations, and whose work serves as a jumping-off point which sets out which gaps need to be filled; they are careful to separate out their recommendations for high-resourced settings from those for low-resourced settings. But it reinforces the concern highlighted above: that by presenting an apparently authoritative, generalisable model based on a restricted range of settings, these GMH recommendations potentially lend themselves to policy and practice that override local initiatives, meanings and

contextual factors elsewhere. Social work's distinctive theoretical focus on socio-economic and cultural context could provide a valuable corrective to this problem.

What forms of evidence are permitted to contribute to knowledge? Some scholars fear that GMH may become the unwitting vanguard of psychopharmaceutical expansion beyond traditional markets in HICs (Das and Rao, 2012, p. 385), with extension of the right to treatment masking the aggressive growth of medicalisation. In fact, many leading figures in GMH show appreciation of social psychiatric perspectives, and investigate the evidence-base for psychosocial techniques as well as interventions focusing on medication when making recommendations (Patel, 2014). Whether balanced appraisal at this level of the range of interventions is always reflected on the ground is another matter (Jain and Jadhav, 2009), for reliance on a 'global' evidence-base risks focusing on those interventions that most easily lend themselves to comparison across settings. Medication will always be seen as 'travelling' more easily than psychotherapeutic or psycho-educational approaches, in which the complexities of language, interpersonal interaction and conceptual models are more evident. Hence it is not surprising that by far the largest part of the evidence-base for GMH consists of studies of pharmaceutical interventions (Das and Rao, 2012, p. 385). Continued vigilance is called for from the GMH community to ensure a balance between improving access to needed medication and resisting wholesale pharmaceuticalisation. Meanwhile, Das and Rao (2012) also make a subtler critique, suggesting that the individualist focus of the Western diagnostic system – which serves as the basis for the MGMH's approach to 'scientific evidence' – distracts attention away from the social context, particularly the state of the health systems through which GMH is to be delivered. The worry here is that the evidence-base likely to be prioritised in 'global' comparisons takes the individual as its unit of analysis, failing to address adequately the social determinants of health. This is an issue which needs to

be repeatedly placed on the agenda of GMH by all involved; social work, with its underpinning theory base constituted in the intersection of the psychological, social, political and economic contexts, is well placed to contribute.

The above concerns do not invalidate the GMH enterprise to incorporate ‘scientific evidence,’ for they are questions facing many fields and some of the difficulties are already being addressed as more evidence becomes available from a wider range of settings. Nor have the *PLoS Med* papers been selected as especially representative of GMH as a whole; as a networked, heterogeneous entity, it can be misleading to single out particular aspects as ‘centres.’ However, they serve to illustrate a potentially uncomfortable tension between this strand of the assemblage and that of broad participation and empowerment, represented by the MGMH. The kind of knowledge transfer that we have been discussing is distinctly ‘top-down,’ and the leaders of GMH were until recently all psychiatrists (Behague, 2008, p. 140). It can be argued that this has given GMH an orientation that has yet to be rebalanced by the movement’s genuine efforts to empower service users and their families. The World Network of Users and Survivors of Psychiatry (WNUSP) critiques the WHO’s Mental Health Action Plan for the lack of attention given to the ethics of involuntary treatment, argues for replacement of the term ‘mental disorders’ by ‘psychosocial disability,’ attacks continuing adherence to the medical model by the WHO and upbraids the movement for dismissing the contributions of non-Western forms of healing to mental health care (WNUSP, 2013). While other service user groups are more enthusiastic about WHO / GMH efforts, service user testimony is not prominent on the MGMH website and service users remain hugely outnumbered by mental health professionals in the membership of the MGMH. The UN Convention on the Rights of Persons with Disabilities (2007) is based, *inter alia*, on

individual autonomy and the freedom to make choices, full participation and inclusion within society, and respect for difference – for these principles to become reality, service users must have a meaningful voice. It is here that social work can make its most valuable contribution to GMH, drawing on its long traditions of advocacy and empowerment to enable individuals' and families' stories to be heard.

Lest these concerns be dismissed as exaggerated or irrelevant to GMH today, we briefly draw on two ethnographic studies to flesh out the above points:

Pharmaceutical Implementation in India

Jain and Jadhav (2009) describe how community mental health policies played out in the northern state of Uttar Pradesh. Despite a long-standing policy commitment to community participation, psychosocial interventions and social development in mental health, reforms in 2002 shifted emphasis to provision of medication. In practice the authors found interactions with patients were overwhelmingly dominated by pharmaceutical prescriptions. Analysis of policy documents and key informant interviews revealed how the 'psychotropic pill' became – in a setting where priorities and accountability were not clear – an easily traceable, implementable and understandable form of service delivery that seemed to bring all other aspects of mental health care into its orbit. Hence social workers and clinical psychologists were subsumed within the aura of 'the doctor' who had the power to prescribe. To their frustration, they were perceived by service users as no more than his 'assistants' (p. 69-70). Jain and Jadhav found that this approach did not work well in engaging service users, who often attended only sporadically for follow-up and treated the service encounter as simply an opportunity to obtain medication. Failure to engage with local meaning and models of mental distress, in the everyday language used by service users and their families, negatively

affected compliance and the regularity of attendance. Despite the best of policy and professional intentions, community mental health thus metamorphosed into a somewhat haphazard, but nakedly pharmaceutical, regime, avoiding the challenges of addressing the complexities of broader issues. What this makes clear is that the focus GMH places on intervention at the policy level with governmental health ministries, and the top-down recommendations for modalities of care, are – though necessary – in no way sufficient to bring about integrated change. Instead, implementation leads to the propagation of a particular kind of knowledge: the psychopharmaceutical.

Embedding Global Knowledge in Context: Ghana

Read's qualitative study of how families live with mental distress in communities in Kintampo raises related issues. Through in-depth exploration of service user and carer experience, she identifies the disjunctures between the Global Mental Health discourse and reality on the ground. Like Jain and Jadhav, Read (2012) argues that the push to scale up services commonly finds the path of least resistance through provision of pharmaceuticals, leading to neglect of indigenised psychosocial interventions. She goes on to show that, contrary to the common assumption that psychotropic medication would be uncritically embraced by those given access to it, Ghanaian families and service users express a number of reservations, often leading them to discontinue their prescriptions. The reasons given are similar to those heard in HICs, but are expressed through local concepts and idioms, which must be understood if service-users are to be engaged successfully. Echoing Jain and Jadhav's finding on the dominance of 'pills,' Read warns that the tendency for the global knowledge of evidence-based medicine to displace local, embedded knowledge results in 'scaling down' of comprehensive provision rather than 'scaling up.' She (2009) has also

questioned the ‘top-down’ approach to human rights reform for mental illness, showing that entering into dialogue with families, communities and providers about the best way to safeguard human rights in mental disorder might be at least as important as focusing on legal and political reform.

The Incorporation of Embedded Knowledge and Social Work

Could global mental health be approached differently, in ways that mitigate the dangers highlighted? Throughout the world, this is already being done, using approaches that privilege direct experience and situated knowledge. Indeed, in keeping with the point made earlier about the plurivocality of GMH, many of these projects are intertwined with GMH itself, or draw some degree of inspiration from it. The key question, however, is how prominent they are, and whether the values that inform them are taken up elsewhere in the movement.

A particularly interesting example of an innovative approach is the Sundarban community mental health programme in India. Our reasons for highlighting this project in particular centre on the values that shaped it, which are highly congruent with the values that suffuse social work. Although developed by outsiders to the region, this initiative was founded upon meaningful community consultation, participatory research and commitment to partnership with local people. Its founders brought vitally important mental health input to a previously underserved population, but the approach they took avoided any agenda to ‘correct’ and educate a population lacking in ‘mental health literacy’ (Mills, 2014). Instead, they took the concerns of community members seriously, grounding the proposed service in community

priorities and infusing it with an understanding of how mental distress was perceived by local villagers. Using tools derived from cultural epidemiology, including participatory mapping, vignettes, focus groups and planning meetings (Chowdhury *et al.*, 2001), service development took place in close collaboration with the local village councils, or *panchayats*, and was informed throughout by the perspectives of service users, local leaders, health workers and community members.

Doing this groundwork seems to have endowed the programme with a rare awareness of local political conflicts and ecology, alternative healers consulted, clients' concerns, and their perceptions of how a mental health service might benefit them. Furthermore, the fact that workers made the effort to find out about these issues, and took care to include community members from all social strata in the process, helped to overcome the generalised low regard in which government health services were held (Chowdhury *et al.*, 2001). The programme's work to reduce self-harm, suicide and substance abuse benefited from the situated understanding that had been built up over time, enabling programme workers to complement 'clinical considerations' with 'community concerns' (Chowdhury *et al.*, 2006, p. 730).

The level of participatory investigation, planning and the range of methodologies that were put into the Sundarban project are perhaps not a realistic option for all service development; it was chosen here for illustration, rather than as a transferable model. Resource and time constraints mean that 'scaled down' approaches might be appropriate in most settings. Yet it is not difficult to imagine the benefits that meaningful engagement might have yielded in the Ghanaian context described by Read, with open, participatory discussion of the advantages and limits of medication, or of how human rights might realistically be put into practice in the

community. Reports from projects elsewhere draw on strengths-based (Davar, 2012), community-based (Chatterjee *et al.*, 2003) or indigenised approaches (Poltorak, 2013) and could also hold lessons for the implementation of global mental health projects. Indeed, valuable work is being done in all corners of the globe (e.g., Korste, 2012). Yet it has been our experience in identifying examples for this article that these lessons are nowhere pulled together as prominently as the ‘packages of care’ have been. Community engagement, close attention to the specificities of context, and empowerment of service users seem to have been downplayed in the development of a globalisable GMH assemblage, as the disciplinary and institutional channels through which GMH knowledge is directed focus attention elsewhere, or submerge these issues in the more directly transferable ‘ingredients’ of interventions.

This is of direct relevance to social workers, social pedagogues and social development workers across the globe⁴. The different strands of GMH are actively shaping the way knowledge about these fields is formulated; if social workers and related professionals do not participate in this process – perhaps out of valid concerns about the lack of a global mandate, or fears of reinforcing professional dominance and hierarchies – it will go ahead without their input.

Initiatives such as the Sundarban programme or the user/peer-led developments listed by Korste illustrate openings to draw on other forms of knowledge for GMH. Social work is well placed to contribute to this undertaking, in three major respects. Firstly, there is the

⁴ While relatively few directly specialise in mental health (WHO, 2011, p. 52), large numbers of non-specialists commonly work with people who have, or are at risk of, mental distress or substance abuse issues (Harrison and Melville, 2010, p. 99).

discipline's theoretical affinity for knowledge informed by psychosocial understandings, which have consistently enhanced the medical perspective on mental distress, both in the global north and global south. Secondly, social work's strong values-based commitment to empowerment, rights and service user participation can enhance these dimensions of GMH by opening up new forms of knowledge and supporting the democratic aspirations of the MGMH. Thirdly, the very focus on embedded knowledge that has fed concerns over the Global Agenda (Webb, 2003) is in many ways the most valuable contribution that can be made; social work's experience of indigenisation and insistence on grounding its knowledge base in applied practice (Smith, 2012) are the best antidotes to any would-be 'one size fits all' prescriptions. Although the features of social work vary hugely across the world, these are consistent strengths of the profession.

There is a danger in pointing to specific examples of social work research from HICs to suggest a way forward, for fear of contributing further to 'travelling knowledge' that may rapidly become prescriptive in its effects. However, it is worth noting the existence of an important evidence-base in the social work literature that potentially provides a solid grounding for these three dimensions of practice within GMH. In summarising this research into successful recovery, Tew (2013) lists five key elements that have been demonstrated to shape more positive outcomes – empowerment, positive identity, connectedness, hope and a sense of purpose and meaning – which he uses as the basis for the concept of 'recovery capital': a means of assessing individuals' and social networks' existing strengths and pointing ways towards building on them. Because of its recognition of the need to take account of what 'recovery' means to the individual ('personal recovery' as distinct from 'clinical recovery'), recovery research as a whole may or may not offer 'travelling

knowledge' of the kind that lends itself to packaging as standardised interventions; nevertheless, psychosocial factors identified within this paradigm have repeatedly been shown to be central to the course of mental disorder, at least in North America, the UK, Scandinavia and Australia, where most such studies have been carried out (Leamy et al., 2012). Social inclusion, usually through remunerated employment, and positive, reciprocal social relationships with family, friends, and sometimes professionals, are recurrently linked to recovery in both qualitative and evaluation studies (Bradshaw, Roseborough and Armour, 2006; Schön, Denhov and Topor, 2009; Tew et al., 2012; Topor et al., 2011),⁵ providing strong impetus for social work to reinforce its long-standing focus in these areas. Closely interlinked with these variables are the effects of stigma on the individual, and the undermining of their self-efficacy and self-identity. To counteract these, moves towards the provision of mutual support among service-users have both reinforced self-efficacy and proved therapeutically effective (Mancini, 2007; Tew et al., 2012), while social workers have made progress by highlighting and challenging discriminatory social processes at three levels: with the service-users affected by them, at community level, and with fellow professionals whose own practice may be disempowering (Tew et al., p. 450). The emphasis through much of this work is on recasting the relationship between service users and professionals so that the latter assist on the path to recovery rather than dictating the route.

Leamy et al. (2012, p. 450) highlight the predominance of North American research in the recovery literature and it largely remains to explore what issues from it stand out as most

⁵ It is worth noting in passing that in seeking to explain the apparently more positive outcomes for schizophrenia in LAMICs by comparison with HICs, it is these same protective factors that have generally been suggested to be operating (see Warner, 2009).

salient for the diverse populations of LAMICs, where service users, their communities and mental health workers face different socio-economic and cultural circumstances, and whose voices so far have little presence in the international recovery literature. The implications in regard to GMH are that, while social work can, should, and no doubt will contribute to the development of an evidence-informed knowledge base regarding ‘what works’ and aspiring to a significant degree of generalisability, much of which may take its starting point from the existing findings on recovery, its distinctive contribution could lie in finding the ways to reconcile this knowledge base with the specificity of embedded implementation. This can be done through formal research that gives due consideration to the social, cultural and economic determinants of mental distress in particular settings, but it is just as important that it is done through the sharing of situated practice and experience. Practice and service user knowledge should be aired by putting them on the MGMH record and passing on experiences, precisely because this is something that can be done by all involved in mental health, not just by the relatively few academic and professional researchers able to be active in low-income settings. Such an approach allows the MGMH to fulfil its democratic potential.

It may be asked whether there is any role for social work academics and professionals based, like us, in HICs in the proposed emphasis on situated practice and service user knowledge. In keeping with the lessons of Sundarban, we do not believe that a focus on situated knowledge necessarily excludes the contribution of outsiders; rather, it prescribes due respect for context, lived experience and the resultant dialogue. A neglected dimension of ‘global north-south’ exchange is the extent to which HICs can learn from the resourcefulness and flexibility of mental health provision in LAMICs where funds have always been scarce (Korste, 2012).

This is worth bearing in mind in the cross-national sharing of skills, to guard against the replication of familiar hierarchies that privilege Euro-American expertise in mental health and to enrich the profession everywhere.

Finally, there is the need to strengthen the profession worldwide if its input into GMH is to have credibility both locally and internationally. This brings us back to the intent behind the Global Agenda. The points we have raised above hopefully act as a reminder of the resourcefulness that social work brings to the questions raised by GMH; by increasing input into GMH these strengths will be visibly affirmed. *Pace Webb (2003)*, boosting social work's status on the global stage is not just a matter of improving institutional status, but a means to the end of enabling social work perspectives to be heard and inform undertakings of the scale of GMH.

Conclusion

Social work has not so far had a high profile in GMH. This may be partly due to doubts about the advisability of a 'global' scope for social work, partly due to the relative weakness of the worldwide profession compared with health professionals, and partly due to uncertainty as to where its contribution might lie in an environment clearly favouring 'travelling' knowledge over 'embedded' knowledge. However, it misses an important chance to chart the contribution the discipline can make and ensure that GMH knowledge acquires a social work tinge, facilitating participation, empowerment and social perspectives. Consideration of the debates and trends in GMH shows the need for this to happen. In response, it is important for

social work to play its part in building up a global knowledge base constituted as much of the particular as of the general.

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